SCOPE OF SERVICES

1. Required Services

Contract Period: July 1, 2015 through June 30, 2017

The Contractor shall:

1.1. Implement the 2015 Regional Strategic Plan for Prevention pertaining to communities in their region addressing substance misuse prevention and related health promotion as it aligns with the existing three-year outcome-based strategic prevention plan completed September 2015, located at: http://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm.

1.2. Develop regional public health emergency response capabilities in accordance with the Centers for Disease Control and Prevention's (CDC's) Public Health Preparedness Capabilities: National Standards for State and Local Planning (Capabilities Standards) and as appropriate to the region.

1.3. Ensure the administrative and fiscal capacity to accept and expend funds provided by the Department of Health and Human Services' (DHHS), Division of Public Health Services (DPHS) and Bureau of Drug and Alcohol Services (BDAS) for other services as such funding may become available.

1.4. School-Based Seasonal Influenza Vaccination Services

1.4.1. Implement vaccination programs against seasonal influenza in primary, middle, and high schools based on guidance and protocols from the NH Immunization Program (NHIP).

1.4.2. Recruit public and non-residential private schools to participate in school-based clinics based on priorities established by the DPHS. Priorities may be based on socioeconomic status, prior year vaccination rates, or other indicators of need.

1.4.3. School influenza vaccination clinics must be held during the school day (approximately 8 A.M. to 4 P.M.) and on school grounds.

1.4.4. As requested by the DPHS, use the IRMS to manage vaccine provided under the auspices of the DPHS NHIP.

1.4.5. Submit all required documentation for immunized individuals to the NHIP within 10 business days after each clinic.

1.4.6. Report all known adverse reactions according to protocols established by the NHIP.

1.4.7. Dispose of all biological waste materials in accordance with regulations established by the State of New Hampshire.

1.4.8. Conduct debriefings after each clinic to identify opportunities for improvements.

1.5. Regional Public Health Advisory Committee

1.5.1. Continue a regional Public Health Advisory Committee (PHAC) comprised of representatives from the community sectors identified in the table below. At a minimum, this PHAC shall provide an advisory role to the contractor and, where applicable, all subcontractors to assure the delivery of the services funded through this agreement.

1.5.2. The PHAC membership should be inclusive of all local agencies that provide public health services in the region beyond those funded under this agreement. The purpose is to facilitate improvements in the delivery of the 10 Essential Public Health Services including preparedness-related services and oversight of substance misuse through the continuum of care (prevention, intervention, treatment and recovery) as appropriate to the region. This is accomplished by establishing regional public health priorities that are based on assessments of community health; advocating for the implementation of programs, practices and policies that are evidence-informed to meet improved health outcomes; and advance the coordination of services among partners.

1.5.3. As federal funders, both the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration have developed lists of key community sectors. While described in different ways, the two lists encompass the same community sectors as evident in this table.

Substance Misuse Prevention and Related Health Promotion	**Public Health Preparedness**
Community Leadership*	
Local Government Safety and Enforcement	Emergency Management
Health and Medical	Health Care Mental / Behavioral Health
Community and Family Support	Cultural and Faith-based Organizations Housing and Sheltering Senior Services Social Services
Business	Business Media
Education	Education and Child Care

*This CDC sector is defined as leaders with policy and decision-making roles, including elected and appointed public officials, leaders of non-governmental organizations and other community-based organizations. Thus, this sector includes leaders from all of the other sectors in this table.

1.6. Membership

1.6.1. At a minimum, the following entities within the region being served shall be invited to participate in the PHAC in order to achieve a broad-based advisory committee comprised of senior leaders from across sectors and communities. It is expected that

the larger PHAC will be supported by committees/workgroups, etc. comprised of professionals with more specific topical and/or function-based expertise.

1.6.2. PHAC General Membership

1. Each municipal and county government
2. Each community hospital
3. Each School Administrative Unit (SAU)
4. Each DPHS-designated community health center
5. Each NH Department of Health and Human Services (DHHS)-designated community mental health center
6. The contractor
7. Representative from each of the following community sectors shall also be invited to participate: business, cultural and faith-based organizations, social services, housing and sheltering, media, and senior services.
8. Representatives from other sectors or individual entities should be included as determined by the Regional Public Health Advisory Committee.

1.5.5.1. PHAC Executive/Steering Committee Membership

1.5.5.2. For PHACs that include an executive or steering committee, the Contractor shall strive to ensure representation from the following entities.

1. One municipal and county government
2. One community hospital
3. One School Administrative Unit (SAU)
4. One DPHS-designated community health center
5. One NH Department of Health and Human Services (DHHS)-designated community mental health center
6. The contractor
7. Other business, cultural and faith-based organizations, social services, housing and sheltering, media, and senior services.

1.5.5.3. Representatives from other sectors or individual entities should be included as determined by the Regional Public Health Advisory Committee.

1.6. Perform an advisory function to include:

1.6.1. Collaborate with partners to establish annual priorities to strengthen the capabilities within the region to deliver public health services, including public health emergencies and substance misuse through the continuum of care.

1.6.2. Collaborate with regional partners to collect, analyze and disseminate data about the health of the region.

1.6.2.1. Monitor and disseminate data products and reports to public health system partners in the region in order to inform partners about the health status of the region. Disseminate other reports (ex. Weekly Early Event Detection Report) issued by DHHS as appropriate.

1.6.2.2. Educate partners on the NH WISDOM data repository, in order to build capacity to utilize this system to generate and analyze regional data.

1.6.2.3. Participate in local community health assessments convened by other agencies.

1.6.3. Designate representatives of the PHAC to other local or regional initiatives that are providing public health services, including public health emergencies and substance misuse through the continuum of care.

1.6.4. By September 30, publish the Community Health Improvement Plan (CHIP) started in SFY 15.

1.6.4.1. Disseminate the CHIP to regional partners and seek opportunities to educate the community about CHIP priorities, strategies, and activities.

1.6.5. Implement priorities included in the 2015 CHIP.

1.6.5.1. Provide leadership to implement the priorities and strategies included in the CHIP.

1.6.5.2. Implement specific activities for at least one CHIP priority in addition to public health emergency preparedness and substance misuse prevention.

1.6.5.3. Monitor progress of CHIP implementation and provide an annual report describing programs and activities implemented that address CHIP priorities to regional partners and DHHS.

1.6.6. Maintain a set of operating guidelines/principles or by-laws related to the Regional Public Health Advisory Committee that include:

a) Organizational structure
b) Membership
c) Leadership roles and structure
d) Committee roles and responsibilities
e) Decision-making process
f) Subcommittees or workgroups
g) Documentation and record-keeping
h) Process for reviewing and revising the policies and procedures

1.6.7. Assist in the implementation of the biennial PARTNER survey of the PHAC membership.

1.6.8. Implement the PARTNER survey in SFY 2016.

1.6.8.1. Host at least one meeting to share results from the PARTNER survey with regional partners.

1.6.9. Maintain a webpage related to the PHAC.

1.6.10. Attend semi-annual meetings of PHAC leaders convened by the DHHS. Attendees should include a representative of the Contractor and at least one PHAC member.

1.6.11. The chair of the PHAC or their designee should be present at site visits conducted by the NH DPHS and BDAS and, to the extent possible, be available for other meetings as requested.

1.7. Substance Use Disorders, Resiliency and Recovery-Oriented Systems of Care

1.7.1. Development of organizational structures needed within each of the Regional Public Health Networks to study and develop capacity for a seamless substance misuse continuum of care approach that includes: environmental strategies, prevention, early intervention, treatment and recovery support services. Activities will include training, education, and orientation for Public Health Advisory Councils in substance misuse and the progression of substance use disorders and its effect on individuals, families, and communities, including financial impact. This work will include outlining a comprehensive approach to address the misuse of alcohol and drugs within a Resiliency and Recovery Oriented System of Care context.

1.7.2. Building on information from the Regional Continuum of Care Roundtables, and using local expertise as much as possible, the Contractor will develop and implement a work plan to:

1.7.2.1. Recruit and convene subject matter experts, consisting of local healthcare providers and other professionals within the continuum of services to form a workgroup who will help plan, implement and facilitate these deliverables within Resiliency and Recovery Oriented Systems to educate the Public Health Advisory Council about an integrated/collaborative continuum of care Substance Use Disorder strategies and services.

1.7.2.2. Provide education, training and information to Public Health Advisory Council on the impact of the misuse of alcohol and drugs to help members:

1.7.2.2.1. Understand the nature of substance use disorders;

1.7.2.2.2. Learn about the impact of substance use disorders on individuals, families and communities;

1.7.2.2.3. Increase their knowledge of the financial impact of substance use disorders – at the state level, community level, and community sector level;

1.7.2.2.4. Understand the relationship between, and integration of, healthcare and behavioral health, and its relationship to misuse of substances and substance use disorders;

1.7.2.2.5. Learn about the components of Resiliency and Recovery Oriented Systems of Care what they do, and the interrelationship with:

Environmental strategies, Prevention services, Intervention services, Treatment services, Recovery support services

1.7.2.3. Discover, understand and envision a comprehensive approach to preventing, treating and recovering from substance use disorders.

1.7.2.4. Connect with and recruit representatives from Community Health Centers, hospital networks and local primary care so that they can provide information to the Public Health Advisory Council on the integration of healthcare and behavioral health, e.g. Screening and Brief Intervention and Referral to Treatment and other evidenced informed practices.

1.7.2.5. Work with Substance Misuse Prevention Coordinator and local prevention coalitions to present information on prevention to the Public Health Advisory Council and the role prevention plays in the continuum of services and Resiliency and Recovery Oriented Systems of Care.

1.7.2.6. Connect with and recruit representatives from intervention/treatment providers to provide information on treatment to the Public Health Advisory Council, and the role intervention/treatment plays in the continuum of services and Resiliency and Recovery Oriented Systems of Care.

1.7.2.7. Connect with and recruit representatives from the recovery community to provide information on recovery and recovery supports to the Public Health Advisory Councils, and the role recovery supports play in the continuum of services and Resiliency and Recovery Oriented Systems of Care.

1.7.2.8. Familiarize the Public Health Advisory Council with the “Misuse of Alcohol and Drugs” section of the State Health Improvement Plan to prepare them for the development of the Community Health Improvement Plan described in the section above.

1.7.2.9. The Center for Excellence, a technical assistance contractor to the Bureau of Drug and Alcohol Services, will provide materials and host a webinar on elements of a comprehensive system in environmental strategies, prevention, intervention, treatment, and recovery from substance use disorders.

1.8. Substance Misuse Prevention (SMP) and Related Health Promotion

1.8.1. Maintain and/or hire a full-time-equivalent coordinator(s) to manage the project with one person serving as the primary point of contact and management of the scope of work.

1.8.1.1. The Prevention Coordinator(s) is required to be a Certified Prevention Specialist (CPS) or pending certification within one year of start of contract and a graduate from a four year university.

1.8.1.2. Provide or facilitate appropriate professional office space, meeting space, and access to office equipment to conduct the business of the Regional Public Health Network (RPHN).

1.8.1.3. Ensure proper and regular supervision to the Coordinator(s) in meeting the deliverables of this contract.

1.8.2. Ensure the continuance of a committee to serve as the content experts for Substance Misuse Prevention and Related Health Promotion and associated consequences for the region that is under the guidance of and informs the Regional Public Health Advisory Council.

1.8.2.1. The expert committee shall consist of the six sectors, Drug Free Coalitions, Student Assistance Counselors and other grass roots coalitions' representation of the region with a shared focus on substance misuse prevention, the associated consequences and health promotion.

1.8.2.2. The committee will inform and guide regional efforts to ensure priorities and programs are not duplicative but rather build local capacity that is data-driven, evidence-informed, and culturally appropriate to achieve positive outcomes.

1.8.2.3. Ensure the expert committee provides unbiased input into regional activities and development, guidance in the implementation of the strategic plan.

1.8.2.4. Portion of the committee or a member serves as the liaison to the Regional Public Health Advisory Committee.

1.8.3. Attend, assist and participate with the Continuum of Care facilitator and the Continuum of Care work group in the regions' capacity development in continuum of care services.

1.8.4. Develop and implement substance misuse prevention three-year regional strategic plan.

1.8.4.1. Current one-year work plan is good through to Sept 29, 2015 and is available at: http://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm.

1.8.4.2. Three-year strategic plan due by September 30, 2015 that is aligned with the Collective Action and Collective Impact Plan http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf, and the State Health Improvement Plan (SHIP) http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf and the region's Community Health Improvement Plan (CHIP).

1.8.4.3. Regional strategic plan needs to be endorsed by expert committee and approved by the PHAC prior to submission to BDAS for approval. PHAC letter of approval is due at the time of submission.

1.8.4.4. Three-year plan needs to be approved by BDAS prior to implementation.

1.8.5. All programs and practices need to be evidenced-informed approaches for substance misuse prevention as outlined in the following document: http://www.dhhs.nh.gov/dcbcs/bdas/documents/evidenceinformedpx.pdf.

1.8.6. Maintain effective training and on-going communication within the Regional Public Health Network, expert committee, PHAC, broader membership, and all subcommittees. Promote the regions substance misuse prevention strategic plans' goals, objectives, activities and outcomes promoted through media and other community information channels and other prevention entities as appropriate.

1.8.7. Utilization of the Strategic Prevention Framework (SPF) five-step planning process to guide regions/communities in the data driven planning process planning, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities http://www.samhsa.gov/spf.

1.8.8. Substance misuse prevention plans and regional efforts need to adhere to the Federal Substance Abuse Prevention and Treatment Block Grant requirements:

1.8.8.1. Prevention approaches must target primary prevention strategies. These strategies are directed at individuals not identified to be in need of treatment.

1.8.8.2. Comprehensive primary prevention program shall include activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to the Center for Substance Abuse Prevention categories: Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-based Process, and Environmental.

1.8.8.3. A comprehensive approach using the above categories targeting populations with different levels of risk classified by the Institute of Medicine Model: Universal, Selective, and Indicated.

1.8.8.4. All the above information in more detail is outlined under the heading Primary Prevention: http://www.samhsa.gov/grants/block-grants/sabg.

1.8.8.5. Assist the state in meeting the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS) through data collection, evaluation and process measures via the PWITS online data system. These regulatory requirements are described and posted on the BDAS website: http://www.dhhs.nh.gov/dcbcs/bdas/documents/bg-px-noms.pdf

1.8.9. Cooperate with and coordinate all evaluation efforts as required by BDAS and DPHS as conducted by the Center for Excellence (e.g. PARTNER Survey, SMP stakeholder survey and all other surveys as directed by BDAS).

1.8.10. Attend all State required trainings, workshops, and bi-monthly meetings and ongoing quality improvement as required demonstrated by attendance and participation with Center for Excellence technical assistance events and learning collaborative(s).

1.8.11. Must respond to BDAS and DPHS emails and inquiry's within 3 to 5 business days or time stated.

1.8.12. Must cooperate with all BDAS site visits as required; at minimum one annually.

1.8.13. Work with BDAS and the Bureau of Liquor Enforcement to institute Comprehensive Synar Plan activities (merchant and community education efforts, youth involvement, policy and advocacy efforts, and other activities). http://www.samhsa.gov/synar.

1.8.14. Coordinate with your RPHN contract administrator in the development and the ongoing maintenance of a Substance Misuse Prevention and Health Promotion website with links to drugfreenh.org and Bureau of Drug and Alcohol Services.

1.8.15. Assist with other State activities as required by BDAS or DPHS.

1.9. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

1.9.1. The Public Health Advisory Council (PHAC) will provide support for the development of regional capacity for a comprehensive, accessible continuum of care for substance use disorder that supports the state plan recommendations, best practice and Department of Health and Human Services priorities. A comprehensive service array will include developing needed capacity for environmental strategies, prevention, early intervention, treatment and recovery support services. The PHAC will promote the utilization of a Resiliency and Recovery-Oriented System of Care – RROSC (whole person) construct in an effort to minimize the prevalence and consequence of substance misuse in each region. RROSC is a coordinated effort that supports person-centered approach that builds on the strengths and resiliencies of individuals, families, and communities (http://www.dhhs.nh.gov/dcbcs/bdas/index.htm). The work will include:

1.9.1.1. Participation in ongoing education on comprehensive approaches to addressing substance misuse through the development of a regional continuum of care.

1.9.2. Hiring and providing support for one (1) dedicated full-time Continuum of Care (CC) Facilitator to:

1.9.2.1. Be trained in the evidence-based Strategic Planning Model (five steps: Assessment, capacity, develop a plan, Implement the plan, evaluation), Resiliency and Recovery-Oriented System of Care tenants, and NH Comprehensive Systems of Care

1.9.2.2. Ongoing attendance and participation in Regional PHAC meetings and planning.

1.9.2.3. Use the Strategic Planning Model to assess services availability within the continuum of care: prevention, intervention, treatment and recovery support services, including the regions' current assets and capacity for regional level services.

1.9.2.4. Assessment of substance use disorder service within the NH Health Improvement Plan benefits.

1.9.2.5. Work with partners to establish a plan, based on the assessment, to address the gaps and build the capacity to increase substance use disorder services across the continuum.

1.9.2.6. Develop mechanism to coordinate efforts between key Prevention, Intervention, Treatment and Recovery stakeholders.

1.9.2.7. Reconvene or recruit subject matter experts consisting of local (when possible) healthcare providers and other professionals within the continuum of services to form the CC workgroup to assist, coordinate efforts.

1.9.2.8. Develop a plan for communication and for respective roles and responsibilities of the continuum of care workgroup.

1.9.2.9. Work with BDAS and its technical assistance partners to address education, training and technical assistance needs.

1.9.2.10. Recruiting representatives from community health centers, community mental centers, hospitals, primary care, and other health and social service providers to help further efforts in the integration of healthcare and behavioral health by:

1. Promoting substance use screenings at sites at appropriate locations;
2. Providing information on substance misuse trainings available for healthcare and other behavioral health providers;
3. Communicating resources available to address substance misuse issues.

1.9.2.11. Assisting in the continuation or development of a Continuum of Care work group that includes local expertise in:

1. Prevention:Work with the Substance Misuse Coordinator and prevention providers to identify assets, address areas of need and increase access to prevention services;Coordinates this work with the regional three-year strategic prevention plan (available at: https://www.dhhs.nh.gov.bdas/prevention.htm).
2. Intervention/Treatment:Work with Intervention and treatment providers to identify assets, address areas of need and increase capacity and to improved access to services;To develop and maintain established quality standards.

3. Recovery:Work with recovery service providers, including peer led organizations, to identify assets, address areas of need and increase access to services.Work with recovery service providers to enhance or increase services, and/or develop new services.
4. Primary Healthcare/Behavioral Health:Work with primary healthcare providers and behavioral health providers to develop means of integrating substance misuse services, mental health and primary care services within the region, including health promotion.Work with healthcare and behavioral health providers to enhance or increase substance misuse screening other services, and/or develop new services.
5. Based on the work above, develop a format that tracks and makes available information on Prevention, Intervention, Treatment and Recovery resources.

1.9.2.12. Participation with all trainings, technical assistance and evaluations as directed by BDAS

1.10. Staffing Requirements

1.10.1. CONTINUUM OF CARE FACILIATATOR – dedicated full time position

1.10.1.1. This position works with the RPHN and communities to ensure that all necessary partners for the development of a comprehensive continuum of care as described above, and that aligns with the regional Community Health Improvement Plan. These partners should include substance use Prevention, Intervention, Treatment, and Recovery providers, healthcare and behavioral health providers, and other interested or affected parties. The Continuum of Care facilitator will work with BDAS and its technical assistance resources to ensure that all partners have access to information, training and/or technical assistance necessary for them to understand and fully participate in continuum of care development discussions and planning.

1.10.1.2. Qualifications:

1. MPH with focus on systems development or,
2. MSW with focus or experience in macro social work or,
3. Master's degree in Community Development/Organizing or,
4. BA in the any of the above with 2-3 years' experience in public health systems development, macro social work, or community development/organizing.

1.11. Regional Public Health Preparedness

1.11.1. Regional Public Health Emergency Planning

1.11.1.1. The goal of these activities is to provide leadership and coordination to improve the readiness of regional, county, and local partners to mount an effective response to public health emergencies and threats. This will be achieved by conducting a broad range of specific public health preparedness activities to make progress toward meeting the national standards described in the U.S. Centers for Disease Control and Prevention's (CDC) Public Health Preparedness Capabilities (March 2011). All activities shall build on current efforts and accomplishments within the region. All revisions to the regional preparedness annex and appendices, as well as exercises conducted under this agreement will prioritize the building and integration of the resource elements described in the Capabilities Standards.

1.11.1.2. In collaboration with the PHAC described in Section 3.1, provide leadership to further develop, exercise and update the current Regional Public Health Emergency Annex (RPHEA) and related appendices. The RPHEA is intended to serve as an annex or addendum to municipal emergency operations plans to activate a regional response to large-scale public health emergencies. The annex describes critical operational functions and what entities are responsible for carrying them out. The regional annex clearly describe the policies, processes, roles, and responsibilities that municipalities and partner agencies carry out before, during, and after any public health emergency. For more information about the format and structure of emergency plans go to: https://www.fema.gov/media-library/assets/documents/25975.

1.11.1.3. As requested by the DPHS, participate in review of the RPHEA and, related appendices and attachments. Revise and update the RPHEA, related appendices and attachments based on the findings from the review.

1.11.1.4. Participate in an annual Medical Countermeasure Operational Readiness Review (MCM ORR) as required by the CDC Division of Strategic National Stockpile (DSNS). The MCM ORR outlines planning elements specific to managing, distributing and dispensing Strategic National Stockpile (SNS) materiel received from the CDC during a public health emergency. Revise and update the RPHEA, related appendices and attachments based on the findings from the MCM ORR.

1.11.1.5. Develop new incident-specific appendices based on priorities identified by the NH DPHS. The DPHS will provide planning templates and guidance for use by the contractor.

1.11.1.6. Submit the RPHEA and all related appendices and attachments to the NH DPHS by June 30 of each year. Submission shall be in the form of a single hard copy and by posting all materials on E-Studio. E-Studio is a web-based document sharing system maintained by the DPHS.

1.11.1.7. Disseminate the RPHEA and related materials to planning and response partners, including municipal officials from each municipality in the region. Dissemination may be through hard copy or electronic means.

1.11.1.8. Collaborate with hospitals receiving funds under the U. S. DHHS' Hospital Preparedness Program (HPP) cooperative agreement to strengthen and maintain a healthcare coalition in accordance with the "Healthcare Preparedness Capabilities-National Guidance for Healthcare System Preparedness." Healthcare coalitions consist of a collaborative network of healthcare organizations and their respective public and private sector response partners. Healthcare coalitions serve as a multi-agency coordinating group that assists local Emergency Management and Emergency Support Function (ESF) #8 with preparedness, response, recovery and mitigation activities related to healthcare organization disaster operations.[1]

1.11.1.9. Collaborate with municipal emergency management directors to integrate the assets and capabilities included in the RPHEA into municipal and regional shelter plans.

1.11.1.10. Pursue Memorandums of Understanding (MOUs) with governmental, public health, and health care entities that describe the respective roles and responsibilities of the parties in the planning and response to a public health emergency.

1.11.1.11. Implement at least one priority intervention identified during the regional Hazard Vulnerability Assessment.

1.12. Regional Public Health Emergency Response Readiness

1.12.1. Engage with community organizations to foster connections that assure public health, medical and behavioral health services in the region before, during and after an incident.

1.12.2. Through the Public Health Advisory Committee, continue to collaborate with community organizations to improve the capacity within the region to deliver the Ten Essential Public Health Services.

1.12.3. Improve the capacity and capability within the region to respond to emergencies when requested by the NH DHHS or local governments.

1.12.4. Coordinate the procurement, rotation and storage of supplies necessary for the initial activation of Alternate Care Sites (ACS), Neighborhood Emergency Help Centers (NEHCs) and Points of Dispensing (POD) and support public health, health care and behavioral health services in emergency shelters located within the region.

1.12.5. As needed, develop and execute MOUs with agencies to store, inventory, and rotate these supplies.

[1] Healthcare Preparedness Capabilities-National Guidance for Healthcare System Preparedness. U.S. Department of Health and Human Services, January 2012.

1.12.6. Enter and maintain data about the region's response supplies in the Inventory Resources Management System (IRMS) administered by the NH DHHS Emergency Services Unit (ESU) in order to track and manage medical and administrative supplies owned by the contractor.

1.12.7. An inventory of regional supplies shall be conducted at least annually and after every deployment of these supplies. Each agency funded under this agreement will be granted administrative access rights to this web-based system in order to complete this activity.

1.12.8. Disseminate information about, and link appropriate public health and health care professionals with, the NHResponds to allow for the timely activation of volunteers during emergency events. For more information about NHResponds go to: (https://www.nhresponds.org/nhhome.aspx).

1.12.9. Disseminate information about the NH Health Alert Network (HAN) and refer appropriate individuals interested in enrolling to the DPHS HAN coordinator. The HAN is an alerting and notification system administered by the NH DPHS. Receive, and act on as necessary, HAN notices from the DPHS to ensure local partners remain aware of recommendations and guidance issued by the DPHS.

1.12.10. Improve capacity to receive and expend funds associated with public health emergency response in a timely manner. Assess the agency's financial, personnel, and procurement/contract management policies and procedures and improve procedures to reduce the time needed to receive and use federal and state funds during emergencies.

1.12.11. Sponsor and organize the logistics for at least two trainings/in-services for regional partners. Collaborate with the DHHS, DPHS, the NH Institute of Public Health Practice, the Community Health Institute in Bow, NH, the Preparedness Emergency Response Learning Center at Harvard University and other training providers to implement these training programs. Enter information about training programs and individuals trained into a learning management system administered by NH DPHS to track training programs. In coordination with the DHHS, participate in a Medical Reserve Corps (MRC) within the region or in cooperation with other regions according to guidance from the federal MRC program and the DHHS.

1.12.12. Conduct outreach to health care entities to recruit health care workers with the skills, licensure and credentialing needed to fill positions described in the RPHEA, and related appendices.

1.13. Public Health Emergency Drills and Exercises

1.13.1. Plan and execute drills and exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP).

1.13.2. Maintain a three-year Training and Exercise Plan (TEP) that, at a minimum, includes all drills and exercises as required under the SNS program.

1.13.3. Based on the mutual agreement of all parties and as funding allows, participate in drills and exercises conducted by the NH DPHS, NH DHHS ESU, and NH Homeland Security and Emergency Management (HSEM). AS funding allows, this includes all drills and exercises conducted by NH DHHS to meet CDC requirements for a full-scale exercise regarding medical countermeasures distribution and/or dispensing.

1.13.4. Collaborate with local emergency management directors, hospitals, and public health system partners to seek funding to support other workshops, drills and exercises that evaluate the Capabilities Standards based on priorities established by regional partners.

1.13.5. To the extent possible, participate in workshops, drills and exercises as requested by local emergency management directors or other public health partners.

2. Performance Measures

2.1. School-Based Vaccinations

2.1.1. Number of schools hosting a seasonal influenza clinic

2.1.2. Percent of total student enrollment receiving seasonal influenza vaccination

2.1.3. Percent of students receiving seasonal influenza vaccination who are enrolled in Medicaid or report being uninsured.

2.2. Regional Public Health Advisory Committee

2.2.1. Representation of at least 70% of the 11 community sectors identified in the CDC Capabilities Standards that participate in the Regional Public Health Advisory Committee.

2.2.2. Representation of 65% of the 6 community sectors identified in the Governor's Commission plan that participate in the Regional Public Health Advisory Committee.

2.2.3. Documented organizational structure for the Regional Public Health Advisory Committee (e.g. vision or mission statements, organizational charts, MOUs, minutes, etc.).

2.2.4. Establish and increase over time regional connectivity among stakeholders and improved trust among partners via the biennial PARTNER Survey.

2.3. Substance Use Disorders, Resiliency and Recovery – Orientated Systems of Care

2.3.5. Number of subject matter experts from across the Continuum of Care Services recruited and serving on the workgroup.

2.3.6. Number of educational resources developed to educate the PHAC.

2.3.7. Number of educational events identified by the delivery modality (face to face meeting, webinars, etc.) to educate the PHAC.

2.3.8. Number of PHAC members educated.

2.3.9. Submission of PHAC endorsed statement/vision on what constitutes a substance use disorder comprehensive approach for your region's system of care.

2.4. Substance Misuse Prevention (SMP) and Related Health Promotion

2.4.5. Completion of 3 year substance misuse prevention plan and endorsed by Regional Public Health Advisory Committee and approved by BDAS due September 30, 2015.

2.4.6. Completed an approved annual workplan reflective of new strategic plan due October 31, 2015.

2.4.7. Completed monthly PWITS data entries due by the 20th business day of the following month (e.g. September data due by October 30).

2.4.8. Data entry needs to align with the 3 year strategic plan for substance misuse prevention and health promotion and adhere to the PWITS Policy Guidance document

2.4.9. Host at minimum 4 SMP expert team meetings annually

2.4.10. Meet all Federal regulatory reporting requirements of the Substance Abuse Prevention and Treatment Block Grant.

2.4.11. Participates and coordinates evaluation surveys: SMP stakeholder survey and other surveys as required.

2.4.12. Participates and coordinates attendees and prepare for BDAS or DPHS site visits. At request of the state you may be asked to convene: SMP coordinator, Contract administrator, financial agent, expert team chair and others as requested.

2.4.13. Attendance at SMP bi monthly meetings jointly convened by BDAS and NH Charitable Foundation.

2.4.14. Maintain a SMP website with links to drugfreenh.org and Bureau of Drug and Alcohol Services.

2.4.15. Provides additional information to BDAS when requested.

2.5. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

2.5.5. One full time dedicated Continuum of Care (CC) facilitator hired and completed all required trainings.

2.4.1.1. CC facilitator establishes and convenes the Continuum of Care (CC) workgroup from across the continuum of care, that includes participants from prevention, intervention, treatment and recovery. Includes Healthcare and primary care providers and behavioral health.

2.4.1.2. Submission of meeting minutes including detailed conversations and action items, CC workgroup attendance,

2.4.1.3. Submission of an assessment of regional continuum CC assets, gaps and barriers to service within nine (9) months of the approved contact to include:

2.4.1.3.1. Identification of gaps in CC components and services that need to be developed or enhanced.

2.4.1.3.2. Identification of barriers to cooperation between CC components.

2.4.1.3.3. Identification of barriers to community/client access to component services.

2.4.1.4. Submission of a plan within one (1) year of the approved contract that identifies actions to address issues in the assessment of regional continuum assets, gaps and barriers to services. workplan outlining the activities to be implemented to resolve any barriers and increase capacity of services within the region

2.6. Regional Public Health Preparedness

2.6.5. Score assigned to the region's capacity to dispense medications to the population based on the CDC MCM ORR.

2.6.6. Number of outreach events with entities that employ health care personnel.

2.6.7. Submission of the RPHEA annually

3. Training and Technical Assistance Requirements

3.1. The contractor will participate in training and technical assistance programs offered to agencies receiving funds under this agreement.

3.2. School-Based Vaccination

3.2.1. Participate in bi-monthly conference calls with New Hampshire Immunization Program (NHIP) staff.

3.2.2. Attend a half-day Training of Trainers in-service program offered by the NHIP.

3.3. Regional Public Health Preparedness

3.3.1. Participate in bi-monthly Preparedness Coordinator technical assistance meetings.

3.3.2. Develop and implement a technical assistance plan for the region, in collaboration with the agency that is under contract with the NH DPHS to provide that technical assistance.

3.3.3. Complete the training standards recommended for Preparedness Coordinators

3.3.4. Attend the annual Statewide Preparedness Conferences in June 2016 and 2017.

3.4. Medical Reserve Corps

3.4.1. Participate in the development of a statewide technical assistance plan for MRC units.

3.5. Substance Misuse Prevention and Related Health Promotion

3.5.1. Participate in bi month SMP meetings

3.5.2. Maintain Prevention Certification credentialing

3.5.3. Ongoing quality improvement is required as demonstrated by attendance and participation with Center for Excellence on or off site technical assistance and trainings.

3.6. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Continuum of Care.

3.6.1. Ongoing quality improvement is required by attendance and participation in on or offsite technical assistance and trainings provided by the Center for Excellence and/or BDAS staff.

4. Cultural Considerations

4.1. The Contractor shall submit a detailed description of the language assistance services they will provide to persons with Limited English Proficiency to ensure meaningful access to their programs and/or services, within ten (10) days of the effective date of this contract.

5. Administration and Management – All Services

5.1. Workplan

5.1.1. Monitor progress on the final workplans approved by the DHHS. There must be a separate workplan for each of the following based on the services being funded:

5.1.1.1. Regional Public Health Advisory Committee

5.1.1.2. Substance Misuse Prevention and Related Health Promotion

5.1.1.3. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

5.1.1.4. Regional Public Health Emergency Preparedness

5.2. Reporting, Contract Monitoring and Performance Evaluation Activities

5.2.1. Participate in an annual or semi-annual site visit with DHHS, DPHS and BDAS staff. Site visits will include:

5.2.1.1. A review of the progress made toward meeting the deliverables and requirements described in this Exhibit A based on an evaluation plan that includes performance measures.

5.2.1.2. Subcontractors must attend all site visits as requested by DHHS.

5.2.1.3. A financial audit in accordance with state and federal requirements.

5.2.1. Maintain the capability to accept and expend funds to support funded services.

5.2.1.1. Submit monthly invoices within 20 working days after the end of each calendar month in accordance with the terms described in Exhibit B, paragraph 3, on forms provided by the DHHS.

5.2.1.2. Assess agency policies and procedures to determine areas to improve the ability to expedite the acceptance and expenditure of funds during public health emergencies.

5.2.1.3. Assess the agency's capacity to apply for state and federal reimbursement for costs incurred during declared emergencies.

5.2.2. Ensure the capacity to accept and expend new state or federal funds during the contract period for public health and substance misuse prevention and related health promotion services.

5.2.3. Submit for approval all educational materials developed with these funds. Such materials must be submitted prior to printing or dissemination by other means. Acknowledgement of the funding source shall be in compliance with the terms described in this contract.

5.2.4. Provide other programmatic updates as requested by the DHHS.

5.2.5. Engage the Regional Public Health Advisory Committee to provide input about how the contractor can meet its overall obligations and responsibilities under this Scope of Services.

5.2.6.1. Provide the Regional Public Health Advisory Committee with information about public health and substance misuse prevention and related health

promotion issues in the state and region that may impact the health and wellness of the public and the ability of communities to respond to and recover from emergencies.

5.2.6.2. Facilitate awareness of the Regional Public Health Advisory Committee about the agency's performance under this Scope of Services by allowing a representative from the Regional Public Health Advisory Committee to participate in site visits and other meetings with the NH DHHS related to the activities being conducted under this agreement.

5.3. Public Health Advisory Committee and Public Health Preparedness

5.3.1. Submit quarterly progress reports based on performance using reporting tools developed by the DPHS.

5.3.2. As requested by the DPHS, complete membership assessments to meet CDC and Assistant Secretary for Preparedness and Response (ASPR) requirements.

5.4. Substance Misuse Prevention and Related Health Promotion

5.4.1. Complete monthly data entry in the BDAS P-WITS system that aligns and supports the regional substance misuse prevention and related health promotion plan.

5.4.2. Contractor will submit the following to the State:

5.4.2.1. Submit updated or revised strategic plans for approval prior to implementation.

5.4.2.2. Submit annual report to BDAS due June 25, 2016 and 2017 (template and guidance will be provided by CEFx).

5.4.2.3. Cooperate and coordinate all evaluation efforts conducted by the Center for Excellence, (e.g. Stakeholder Survey, annual environmental measure, and other surveys as directed by BDAS).

5.4.3. Participate in an annual or semi-annual site visit with DHHS, DPHS and BDAS staff. Site visits will include:

5.4.4. A review of the progress made toward meeting the deliverables and requirements described in this Exhibit A based on an evaluation plan that includes performance measures.

5.4.4.1. Subcontractors must attend all site visits as requested by DHHS.

5.4.5. A financial audit in accordance with state and federal requirements.

5.4.6. Provide additional information as a required by BDAS.

5.5. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional

5.5.1. Contractor will submit the following to the State:

5.5.1.1. Quarterly reports (dates for submission and template will be provided by BDAS).

5.5.1.2. Report on prevention, intervention, treatment and recovery services gap assessment within nine (9) months of the date of contract.

5.5.1.3. Plan to address gaps in services identified within twelve (12) months of the date of contract.